



CIIC

Women's Healthcare in Prison

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The views expressed are those of the authors and should not be attributed to the members of the Correctional Institution Inspection Committee, or any member of the Ohio legislature.

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About CIIC

The Correctional Institution Inspection Committee (CIIC) is a legislative committee of the Ohio General Assembly that maintains a continuing program of inspection of each state correctional institution used for the custody, control, training, and rehabilitation of persons convicted of crime. Per Ohio Revised Code Section 103.73, CIIC has the authority to evaluate and assist in the development of programs to improve the condition or operation of correctional institutions.

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INTRODUCTION

The Correctional Institution Inspection Committee (CIIC) receives hundreds of letters each year from inmates in the Ohio Department of Rehabilitation and Correction (DRC) regarding their medical care. This report is part of a series of CIIC reports on healthcare in the DRC: the first report addressed the overall costs of healthcare; this report narrows the focus to specifically female inmates, who represent a small but growing¹ percentage of the total DRC population. Female inmates report experiencing a higher level of healthcare-related issues and consume a higher amount of healthcare resources, per inmate, than the males do. They therefore deserve special attention by the legislature and the public.

Women's healthcare issues can challenge a corrections department that primarily deals with men. Healthcare issues exclusive to women include reproductive health, including pregnancy and birth, and cancers specific to women (cervical and breast). Women are also frequent consumers of mental health services, are more likely to be on the mental health caseload at an institution, and they are more likely to commit self-injurious behavior, such as cutting and suicide attempts. Additionally, since a disproportionate amount of women are incarcerated due to drug offenses, these women also may have substance abuse issues with secondary physical ailments.²

This paper summarizes Ohio's correctional healthcare system for women, presents a picture of the women in our prisons, their healthcare needs, and the challenges facing the DRC in serving them. To provide a thorough analysis, CIIC reviewed medical data and inmate communication, as well as conducted individual staff interviews at the three primary institutions that housed female inmates prior to 2012. Overall, the paper's intent is to provide a concise, yet complete analysis of the current issues and concerns for women's healthcare in Ohio prisons.

KEY FINDINGS

1. The number of women in Ohio's prisons has increased since 2000. The higher medical and mental health needs of female inmates have resulted in a rise in related costs.

- Ohio currently incarcerates 3,861 women, an increase of 36% since 2000. The DRC spends \$164,710-\$312,856 daily to house, feed, and care for these women (or \$60,119,244 minimum annually).
- Female inmates were seen by institutional nurses and doctors in 29,000-40,000 appointments annually since 2006.³ Additionally, approximately 3,800 inmates were given 162,000-238,000 medications.
- Chronic care patients are those inmates who require regular and ongoing medical services. Since 2009, an average of 1,527 inmates (or approximately 39% of the total female population) have been enrolled in chronic care clinics.

2. Mental health issues affect many of Ohio's female inmates. The majority are entering the institutions with mental health histories (61% in 2010) and currently, half (46-50.5%) of all female inmates are on the mental health caseload.

- Overall, only 11-33% of males in Ohio's prisons are on the mental health caseload.
- The Ohio Reformatory for Women has consistently ranked as the leader in suicide attempts across the DRC (18 since January 2010).

3. Women who enter prison while pregnant receive a variety of specialized services, including prenatal care, labor and delivery, and a nursery for new mothers.

- In 2010-2011, there was a monthly average of 53 pregnant women housed in Ohio's institutions, requiring prenatal, delivery, and postpartum care.
- There were 166 deliveries from January 2010 – May 2011, each ranging in cost from \$3,262.08 to \$9,488.20.
- There have been six to ten inmates living in the ORW nursery with their infants since September 2009 (capacity is 20).

4. Medical staffing issues continue to challenge the DRC, especially at the Ohio Reformatory for Women, which ultimately can affect patient care.

- Multiple staff have relayed that ORW struggles to recruit and retain high quality staff, resulting in high turnover that ultimately affects quality of care.^a
- Though vacancies are usually covered by contract staff while working for the DRC, they do not always receive the same training as permanent staff and may not consistently have the same job duties, unlike permanent staff. This affects overall quality and continuity of women's healthcare, including timeliness of appointments, consistency in diagnosis/treatment, chronic care clinics, and medication prescriptions/refills.
- The backlog of inmates waiting to be seen for chronic care clinics at ORW at the time of the most recent CIIC inspection was 180 (in May 2011), or 10.5% of total enrollments.^b

5. The DRC lacks a program of ongoing education for female inmates on basic hygienic practices and general wellness. At the same time, medical staff have also relayed a desire for additional training and education.

- Female inmates are currently provided basic information regarding how to access institutional healthcare services at orientation. This information session lacks a "health education" component and it occurs during a time period in which the inmate is adjusting to a new environment and dealing with the emotional effects of separation from family and community.
- Educational programs that are needed and not currently provided at all female institutions include group talks, posters, and DVD programs shown on the televisions around the compound, health-focused inmate groups with inmate leaders, and housing units with a health-related mission.
- Medical staff at female facilities relayed a desire for specialized training; however, the combined high turnover and low staffing limit the ability for staff to take the time away from the institution to receive the training.

^a DRC staff relayed that ORW nurses already receive a recruitment / retention bonus. Additionally, they have had leadership turnover in recent years that has also affected staffing. Since April 2011, they have had a consistent manager in place, who is placing greater emphasis on hiring quality employees, and developing staff. Vacancies have been tied to contractual obligations and once ORW was allowed to post, they immediately received applicants. Vacancies were filled with contract staff in the meantime.

^b DRC staff relayed that since the time of the CIIC inspection, less than 10% of the total ORW chronic care caseload has been backlogged, and that the backlog rate was often as low as 2%. As of 12/7/11, they were only 37 backlogged enrollments, or 2.4%.

6. The female population recently experienced an institutional change. The female population is now housed at the Ohio Reformatory for Women, Northeast Pre-Release Center, and Dayton Correctional Institution.

- Medical staff at Dayton Correctional Institution, accustomed to dealing with lower security level, younger, male inmates, will now be treating the female population, which has a much higher rate of healthcare concerns.
- As of the CIIC inspection of Dayton Correctional Institution on October 31, 2011, additional mental health staff had not yet been provided at the facility, but were needed. Staff previously handled fewer than ten inmates on the caseload and will now handle several hundred.

RECOMMENDATIONS

The DRC's Office of Correctional Healthcare has been in a state of evolution and improvement since changes in administration in 2011 at both the DRC Director's level and the Chief of the Bureau of Medical Services, and even before due to the *Fussell* litigation. Discussions with DRC staff revealed that CIIC recommendations, independently developed based on its work in Ohio corrections, were already being discussed by DRC staff. Thus, the following recommendations and action plans are considered mutually agreed-upon goals. CIIC will follow up in two years to evaluate progress and accomplishment.

Recommendation #1

- **The DRC should evaluate the factors that have led to high turnover in medical staff at the Ohio Reformatory for Women and resulting impact on quality and continuity of care. The DRC should consider creating incentives for the recruitment and retention of medical staff.**

DRC Response/Action Plan

- ODRC has received controlling board approval to increase the ceiling on physician salaries to promote recruitment and retention, effective 12/2011.
- ODRC negotiated an agreement with SEIU 1199 (RN Union) to expedite hiring of RNs despite the layoff process taking place in 2011. Without this agreement, ODRC would not have been able to hire civil servants until after January 3, 2012. This agreement was effective in October 2011.
- ODRC will include recruitment and retention initiatives as a subject of bargaining unit negotiations with SEIU 1199 in 2012. ODRC will continue to maintain the current recruitment and retention supplement provided to all shifts for ORW nursing.
- ODRC has language in the existing SEIU 1199 contract allowing recruitment and retention supplement pay for bargaining unit physicians, nurse practitioners, and physician's assistants, which it utilizes to attract providers, especially in hard to recruit areas.

Recommendation #2

- **The DRC needs to ensure that medical and mental health staff are working together to provide holistic treatment for female inmates.**

DRC Response/Action Plan

- ODRC created the Office of Correctional Healthcare at the statewide level in November 2011, combining the medical, mental health, and recovery services bureaus. The merger is intended to introduce a more holistic approach to inmate healthcare needs in ODRC. Policy, practice, and table of organization will be merged by July 2012.

Recommendation #3

- **Education for medical staff in specialty needs to be encouraged and enabled. Agency nurses (temporary workers) especially need education on working in a correctional facility.**

DRC Response/Action Plan

- Effective January 3, 2012, ODRC is utilizing one contractor statewide for temporary nursing and ancillary health services staff. This move will yield multiple efficiencies for ODRC, to include standardization of orientation and expectations for contract staff.
- ODRC is expanding staff educational offerings through a partnership with the Ohio State University Medical Center to utilize their staff in various ODRC training opportunities. This will be effective in March 2012.
- With higher fill rates in nursing produced by the ability to hire, institutional healthcare operations will be better able to allocate staffing resources to training opportunities in 2012.

Recommendation #4

- **The DRC should implement a documented, ongoing education program for inmates that focuses on healthcare topics ranging from basic hygiene to general wellness.**

DRC Response/Action Plan

- By July 2012, ODRC institutions will have wellness programming implemented that focuses on healthy lifestyle habits, including topics reflective of general wellness, hygiene, and both medical and mental health concerns.

Recommendation #5

- **The DRC needs to proactively address the increased healthcare needs of the female population at Dayton Correctional Institution.**

DRC Response/Action Plan

- ODRC has increased staffing at DCI to address the increased healthcare needs of the female populations as follows:
 - Additional 1 Full Time Employee (FTE) of medical advanced level provider
 - Additional 1 FTE Licensed Practical Nurse
 - Additional .5 OB-GYN provider
 - Increased mental health staff coverage from 1 to 5 FTEs
- Additional training was provided to all DCI staff upon movement of the female population to DCI. Focus was on dealing with female offenders generally including their unique healthcare needs. Staff from ORW and NEPRC assisted with the training, sharing their experiences with the female population.

OVERVIEW OF WOMEN'S HEALTHCARE IN PRISON

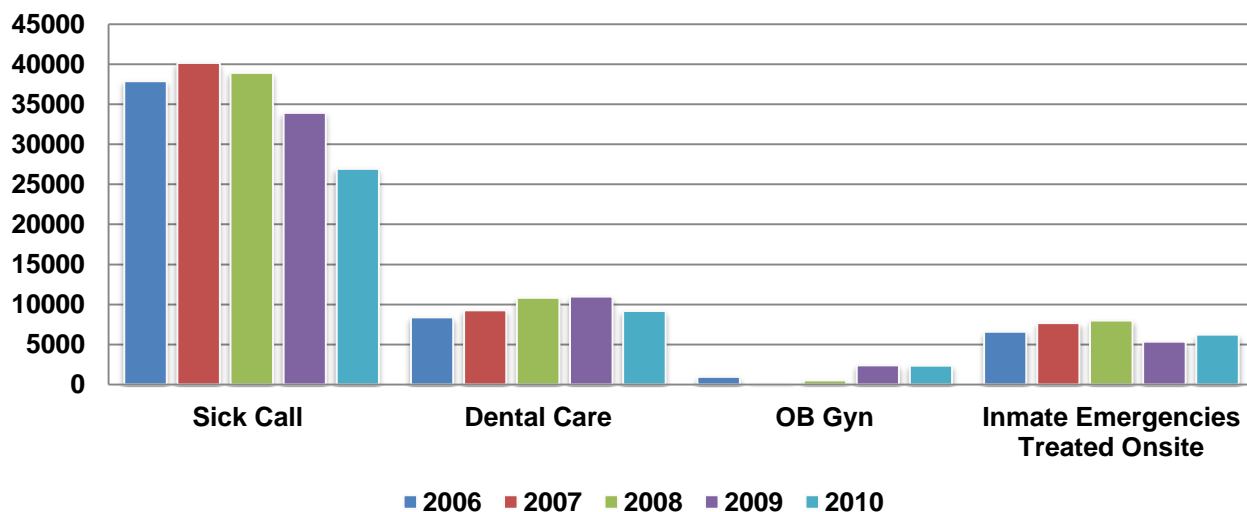
Women represent a growing percentage of Ohio's inmate population, increasing at a faster rate than the male population. As of July 2011, the DRC housed 3,861 female inmates, representing 7.6% of the total inmate population, and an increase of 36% since 2000.⁴ Ohio's female inmate population is predominantly white and 30 years of age or older, with the vast majority incarcerated for crimes against persons, excluding sex crimes, or for drug offenses.⁵

Nationwide, female inmates are more likely than male inmates to report having a medical problem.⁶ Like most offenders, many female inmates neglected their health in the outside community, and come to prison with a higher number of medical complications.⁷ In addition, over half of the women entering Ohio's prisons have serious mental health needs. The typical female offender has a history of substance abuse as well as physical and sexual abuse or all three.^{8,9} Due to the confluence of medical and mental health concerns, female inmates require far greater healthcare resources, per inmate, than the male population.¹⁰

Just as in society, inmates can make an appointment to see medical staff. The inmates submit a health services request form to see the nurse and are typically seen within 48 hours of submitting the form. If the nurse decides the inmate should see the doctor, the inmate is scheduled for "doctor sick call." The doctor's visit can happen immediately, but typically the inmate sees the doctor within a week. Inmates are also given dental care, gynecological services, and emergency care as needed. Additionally, inmates can be sent to an emergency room outside of the prison walls. All inmates also receive a wide variety of specialty care services at the Franklin Medical Center (in conjunction with the Ohio State University Medical Center) or outside providers as deemed appropriate for their condition. Laboratory, podiatry, and optometry services are also available on site.

The following chart depicts a breakdown of the total number of medical services provided to female inmates at the Ohio Reformatory for Women, the Franklin Pre-Release Center, and the Northeast Pre-Release Center from 2006 – 2010.

Medical Services 2006-2010¹¹



The high level of medical services need in the female population is also evident in the large number of women enrolled in chronic care clinics. Chronic care patients must be seen by an advanced level provider (physician, nurse practitioner, or physician’s assistant) on a regular basis in order to “prevent deterioration of the patient’s health.”¹² This regular appointment is referred to as a clinic, which includes a nurse meeting with the inmate to obtain vital signs, reviewing the medical chart to ensure requested information for the advanced level provider is present, and providing education to the inmate. The inmate then sees the advanced level provider for the physical exam to monitor disease control, prescribe medications, and determine the time until the next clinic (either 30, 60, or 90 days).^c

The following chart provides a longitudinal breakdown of total enrollment in chronic care clinics at the three primary female institutions. The difference in numbers between the number of patients and the enrollment is due to the fact that one inmate may be enrolled in multiple clinics based on the inmate’s need.

Number of Chronic Care Patients and Enrollments, 2009-2011¹³

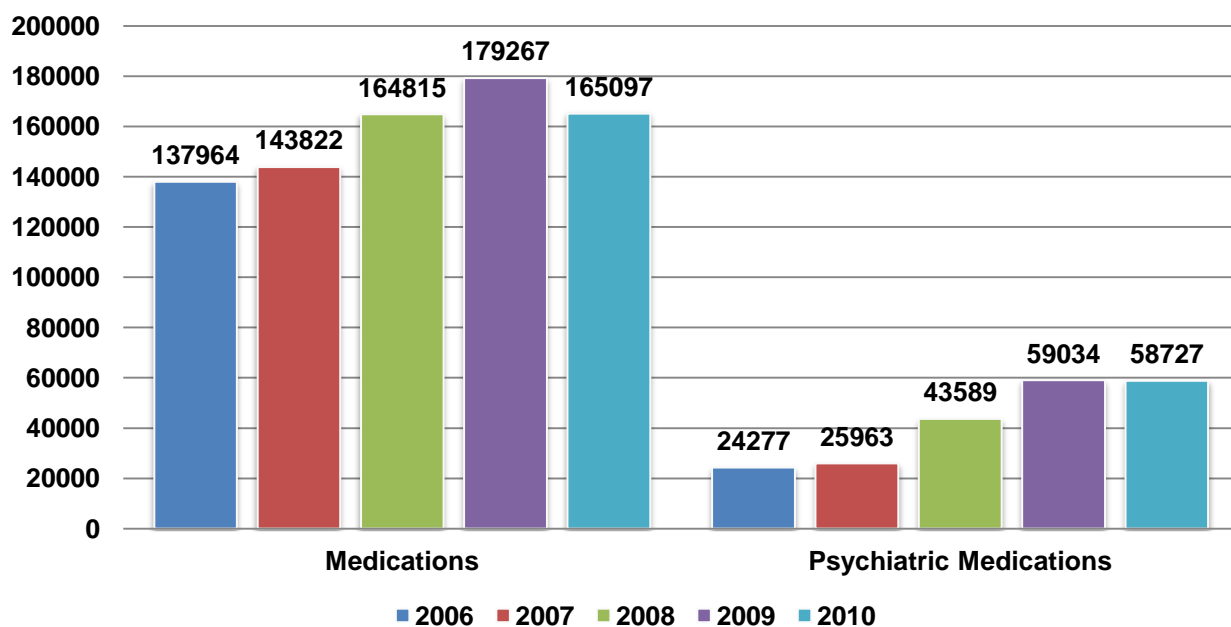
	ORW CC patients	ORW CC enrollment	FPRC CC patients	FPRC CC enrollments	NEPRC CC patients	NEPRC CC enrollments
2009	1013	1390	276	444	279	464
2010	1024	1602	255	448	234	393
2011	1078	1707	184	316	238	398

^c Some patients are scheduled in less than a month and some can be seen every 180 days, although these are the exceptions.

As in male institutions, infectious disease management also forms a component of institutional medical services. In 2009, there were 88 female inmates who tested positive for TB, at least 43 female inmates that were HIV positive, and 20 female inmates who were newly diagnosed with HIV.^d

One of the most costly components of healthcare is the high price of medication.¹⁴ The following chart provides a breakdown of the total medications dispensed to female inmates at the DRC's primary female institutions:

Medications Dispensed 2006 - 2010¹⁵



As shown, there are hundreds of thousands of medications prescribed to Ohio's female inmates annually. These are specifically medications purchased by the state, in addition to the many over-the-counter medications that women may purchase at the commissary, including aspirin, acetaminophen, and vitamins, among others.

^d The DRC frequently identifies HIV infection (previously unknown to the inmates) as part of mandatory testing upon reception. The DRC also tracks conversions (which are indicative of HIV infection spread in prison) and has not found evidence that there is a high incidence of HIV transmission within prison. The DRC conducted a joint study on this particular issue with OSU and the results indicated HIV transmission is not likely in prison.

SPECIAL ISSUES IN WOMEN'S HEALTHCARE

Current issues confronting health care for male and female inmates differ greatly. While male inmates also suffer from mental health conditions and may attempt suicide, a far greater percentage of Ohio's total female population is currently on the mental health caseload and receiving medications for those conditions. Furthermore, gynecological issues, including pregnancy, do not stop simply because the woman has entered the criminal justice system; instead, medical staff at female institutions must be concerned not just for the health of the pregnant women in their care, but also for any as-yet-unborn children that the women may be carrying.

A. MENTAL HEALTHCARE FOR WOMEN

As is true nationally,¹⁶ female inmates in Ohio are more likely than their male counterparts to experience mental health problems.¹⁷ As of June 2011, when compared to similar or larger populations, male institutions report far smaller percentages of their populations on the mental health caseload than female prisons.¹⁸ Only the Oakwood Correctional Facility, previously the DRC's mental health treatment facility, had a higher percentage of inmates on the caseload than the female institutions.¹⁹

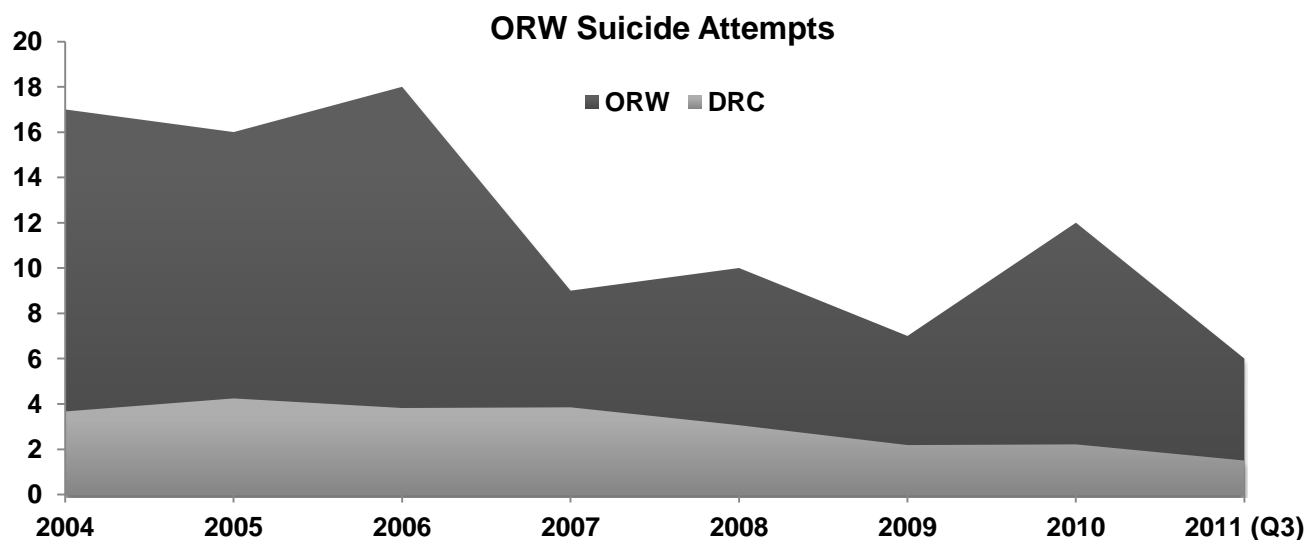
Mental health care concerns confront institutional staff even from the point of intake. The most recent intake study of Ohio's inmates (2010) shows that 61% of females entering Ohio's prisons in 2010 had a history of mental health problems.²⁰ These women do not appear at the institutional door with only one mental health issue to be confronted; instead, women on the mental health caseload most likely have medical issues as well,²¹ creating a confluence of issues that immediately challenge staff.

This challenge is made even more convoluted by the gravity of the women's mental illness. Compared to male institutions, which may only have a small percentage of the mental health caseload classified as seriously mentally ill (SMI), the female institutions report that approximately half of their mental health caseloads are classified as SMI.²²

Suicide, suicide attempts, and self-injurious behavior are all more common for women than men and are especially more common for female inmates. Globally, women are two to three times more likely than men to attempt suicide during their lifetime²³ and they are also more likely to engage in self-injurious behavior.²⁴ A recent study from the UK found that suicide is 20 times more frequent among female prisoners than the greater female population.²⁵ Unsurprisingly, suicide attempts^e in prison

^e "Suicide attempts" generally refer to self-injurious behavior that requires outside medical attention.

disproportionately affect the female population.²⁶ For example, the Ohio Reformatory for Women routinely ranks as the leader in the DRC for total number of suicide attempts.²⁷ The following chart depicts the number of suicide attempts at ORW compared to the male facilities from 2004-2011 (Q3).



B. MOTHERHOOD IN PRISON

Upon admission to a DRC prison, every female is automatically given a pregnancy test.²⁸ If positive, they are referred to a pregnancy coordinator who educates them on their options.²⁹ In Ohio, the options are as follows: elective termination of pregnancy (if within the lawful time period), continuing the pregnancy and apply to care for the infant in the ORW nursery (if criteria are met), or continuing the pregnancy and passing the child to another's care after birth, either through adoption, foster care, or to be raised by family members while the mother is incarcerated.³⁰ Each pregnant woman is given prenatal care, complete with counseling and assistance with decisions.³¹ This care is provided in conjunction with The Ohio State University Medical Center (OSUMC), whose practitioners perform both prenatal care and deliveries.³²

1. Pregnancy

From 2010-2011, the average number of pregnant women incarcerated in Ohio's prisons was 50 per month.³³ Currently, pregnant women are housed at the Franklin Medical Center until the time of delivery, unless security or other reasons require otherwise, at which point they are transported to OSUMC.³⁴

Once identified, all pregnant inmates are also referred for nutritional evaluation and counseling by the institution's dietary staff.³⁵ Routine and high-risk prenatal care is provided by a contractual agreement with OSUMC. Pregnant inmates who are chemically addicted are managed by the institution's physician and the high risk OB/GYN specialist.³⁶ Pregnant women on methadone maintenance therapy^f will be individually evaluated to determine continuance or discontinuance of the therapy.³⁷ After delivery, though, all methadone maintenance therapy is discontinued.

Termination of a pregnancy will be funded by the state only if it is medically necessary for the woman, per both state law and DRC policy.³⁸ Women can also choose a privately funded abortion, performed at an outside clinic.³⁹ These women may be referred to Mental Health Services to determine competency to make such a decision.⁴⁰

2. Delivery

From January 2010 – May 2011, there were a total of 166 deliveries.⁴¹ Per DRC security protocol, for transporting at any time during the pregnancy, pregnant females are only handcuffed in the front of their bodies, without leg irons or belly chains.⁴² No restraints or handcuffs are applied during labor and delivery.⁴³

Delivery does not come cheaply to the state. According to CareWorks (which started management of DRC billing in the second half of 2010), from August 2010 through April 2011, there were 44 deliveries, which cost an average of \$17,057.01, but which had an average payable cost of \$5,117.75 per delivery. Costs^g ranged from a minimum total payable amount of \$3,626.08 to \$9,488.20.⁴⁴

3. Achieving Baby Care Success (ABCS) Nursery Program

Ohio is one of nine states that has a nursery available to inmates located inside the prison walls.⁴⁵ The nursery is funded primarily through a federal grant, which pays for such necessary items as clothes, toys, diapers, wipes, and cribs.⁴⁶ Criteria for admission to the program^h include length of sentence and charge of conviction.⁴⁷ The

^f Methadone maintenance therapy is a treatment program in which methadone is administered in a controlled environment. Methadone is used to treat opiate addiction by blocking withdrawal symptoms.

^g DRC staff clarified that the cost decreases with their negotiated rates, comparable to Medicaid.

^h Per DRC Administrative Rule 5120-9-57, full criteria include the following: (1) She is pregnant at the time she is delivered into the custody of the DRC; (2) She is subject to a prison term of not more than eighteen months; (3) She has never been convicted of a violent crime or any type of child abuse, or child endangerment; (4) She and her child meet established medical and mental health criteria; (5) She is the legal custodian of the child; (6) No one else has been granted custody or shared parenting privileges; and (7) She meets any other criteria established by the DRC.

program has capacity for twenty inmate mothers and twenty-one infants.⁴⁸ From its inception in June 2001 to March 2009, 172 inmates entered the DRC nursery program.⁴⁹

The nursery is housed in the reception dormitory at ORW. It is a locked area that resembles a daycare center. It includes ten cells (each can house two inmates and two infants), a kitchenette, a child eating area, bathrooms separate from the reception inmates, and a common area that has rocking chairs, couches, a television, toys, and books. There are two utility rooms: one for keeping the formula and diapers, and one for infant clothing.

The inmates are permitted to spend no more than eight hours away from their child each day,⁵⁰ including meal times and any educational classes. At the three meal times, the children must be left with another inmate mother or one of the inmate nannies. The children must not be left alone, nor do they ever interact with general population inmates. Educational opportunities include a required minimum of 53 hours of formalized parenting instruction.⁵¹ Women who have not achieved a high school diploma or a GED are required to take educational classes and they are encouraged to participate in recovery service programs, if needed.⁵² Women are also encouraged to seek assistance with parenting. If the inmate is not in educational or vocational programs, she is required to work somewhere at ORW during the day. Medical care is provided to the inmate and the infant. The mothers receive the appropriate medical care needed postpartum. Their infants are given a physical exam each week,⁵³ and there is a pediatrician on call at all times for the child.

The hope is that the mother and child will bond, creating an incentive for the female inmate to not reoffend once she is released.⁵⁴ The parenting education will also assist any other children that the woman may have and for whom she will be responsible once she is released.⁵⁵ Ultimately, the DRC's provision of education and encouragement of mothers' parenting skills will not only directly benefit the families, but – as the increased skills will likely lead to familial unity – also the greater community, which must bear the financial costs of fractured families.

ⁱ Educational programs include 40 hours of training designed by Children's Hospital, Child Passenger Seat Safety, Infant CPR, Be Poison Smart, Developing the Inner Needs of a Child from Birth to Teen, and Emergency First Aid and Infectious Disease.

CURRENT CONCERNS

The DRC has made tremendous improvements in the quality of medical care provided to inmates, mostly as a result of *Fussell v. Wilkinson*, a class action lawsuit filed in 2003 to address inadequate medical care throughout Ohio's prisons.⁵⁶ Current oversight includes regular visits from the *Fussell* monitoring team and regional nursing supervisors from the DRC Operation Support Center, collegial reviews of doctor referrals, greater intervention by DRC attorneys, and data report monitoring.

However, the serious concerns regarding the healthcare of women in prison continue. In 2010, CIIC received 65 contacts from the Ohio Reformatory for Women; of those, 23 (35.4%) relayed serious, disturbing concerns regarding the quality of health care that they received within the institution.⁵⁷ The letters relay allegations ranging from serious staff misconduct to staff refusal or deliberate indifference to inmates' health needs.

At the same time, staff at all three female institutions cited organizational aspects of their work environment that they believe impede the quality of care they can provide. Most of what staff reported in this regard had to do with inconsistent or inadequate staffing, high turnover of experienced nursing leadership and doctors, insufficient space, and equipment that is aging or broken. As is true across the DRC, medical staff at female facilities are having to do more with less due to budgetary restrictions.

A. STAFFING

A key component to providing adequate healthcare to inmates is access to medical staff. Having enough staff to take care of patients is vital to the quality of medical care that can be provided. ORW has the highest number of female inmates and thus the highest number of medical services needed. At the time of the CIIC inspection of ORW, the facility had multiple vacancies in the area of medical services,⁵⁸ reportedly due to contractual obligations, which directly affected patient care.

ORW experiences a high turnover in medical staff and has only recently been able to fill these vacancies with permanent staff due to contractual obligations.⁵⁹ Staff at many DRC facilities have relayed concerns regarding the DRC's ability to recruit and retain high quality medical personnel, but the problem appears to be particularly acute at ORW. Staff have anecdotally relayed reasons for the high turnover, including the difficult population, the institutional staff culture, and the institution's proximity to Columbus, which offers many healthcare jobs that are not located within a prison.⁶⁰

However, the DRC does not appear to have performed a rigorous study or conducted focus groups to fully evaluate the reasons behind the turnover. This is unfortunate, as only by identifying the problems can any solutions be effectively developed.

The most immediate effect of staff vacancies is that it reduces the number of inmates that can be seen. For example, inadequate staffing creates a backlog of female patients waiting to be seen for their chronic care appointment. At the time of the inspection, ORW's staffing deficiencies had created a backlog of almost 180 inmates⁶¹ that were overdue by at least two weeks.^j When fully staffed, as at NEPRC, there is a backlog of zero, meaning all female chronic care patients are seen on time for their chronic care conditions.

High turnover also disrupts continuity of care. An inmate letter from the facility, dated February 23, 2011, relayed the dangers of medical staff turnover: she alleged that her care was passed from one doctor to another with sudden changes in her medications and inconsistency in the doctors' opinions even as to whether she needed surgery.⁶²

ORW's high turnover in medical staff has led to a higher use of agency nurses. While this stopgap measure can at least provide for inmates to be seen on a timely basis, agency nurses may not be familiar with or trained in corrections' practices and policies (as well as inmates), which can affect security. Furthermore, high turnover can require the civil service employees to work many hours of overtime which can lead to high levels of stress and burnout, potentially negatively impacting patient care. Mistakes are more likely to be made, symptoms overlooked, and follow up appointments missed. Female patients may experience delays in being seen by medical staff, or may not be seen at all, when staffing levels are not sufficient to meet the demand for services.

B. QUALITY OF HEALTHCARE AT ORW

Likely related to the above staffing issues, CIIC staff have received letters from female inmates at ORW and have spoken to recently-transferred female inmates at another facility who all allege lack of quality in the healthcare services that they received at ORW. CIIC does not have the expertise to perform an independent audit of medical services and therefore is not endorsing the letters, and yet the amount of anecdotal evidence is disturbing. Each of the most serious letters was relayed to the Warden of the relevant institution and a response was provided that affirmed the level of healthcare provided. Nevertheless, the following concerns can be summarized from the inmate

^j DRC staff noted that this number is likely in terms of enrollments, rather than inmates (one inmate can be enrolled in more than one chronic care clinic). DRC staff also noted that the size of the backlog has been drastically reduced at ORW since the time of the CIIC inspection.

letters: delay in medical care,⁶³ apathetic institutional doctors,^{64,65} and general inadequate treatment.⁶⁶

It should be noted, as stated in the DRC's response to the recommendations, that issues related to staffing have been slowly addressed as the DRC has been able, given contractual obligations, and the level of overcrowding at ORW has decreased due to the conversion of Dayton Correctional Institution to a female facility. Both staffing and overcrowding have an effect on the ability of staff to respond to the healthcare needs of inmates. CIIC has noted a distinct decrease in the number of letters received from ORW inmates with serious medical concerns and therefore is tentatively hopeful that the changes have made a perceptible change in the inmates' medical care.

C. COOPERATION BETWEEN DEPARTMENTS

Medical services must depend on cooperation with several other departments throughout the institution when providing inmate care. For example, in order for an inmate to be seen by medical staff, security staff is usually involved, either through escorting inmates to the medical building, making sure inmates use passes or setting the institutional schedule (such as count time, meal time, and pill call). Most staff reported good interdisciplinary cooperation between security and medical staff despite certain instances where staff of either discipline felt that their concerns overrode the duties of the other. For example, staff at one institution relayed that important security protocols were making it difficult to see patients who were housed in segregation. The leadership of these departments must meet frequently to discuss how these differences can be resolved in order to meet the needs of both disciplines and to ensure the patients are seen on schedule.

Cooperation is especially important between medical and mental health staff. As previously mentioned, approximately half of the female inmates in Ohio's prisons are on the mental health caseload. It is very important for the staff of both medical services and mental health services to work in unison to ensure the patient's needs are met. Female inmates who take psychotropic (mental health) medications receive them from medical staff during pill call, because both medical and mental health medications are in the medical services building only. The nurses from both areas need to work together to ensure that the medications given to the same patient by both departments are mutually appropriate and do not have drug interactions. This can be an issue since mental health and medical records are kept in separate files.

Similarly, if medical staff witnesses inmate behavior that indicates a need for mental health services, they need to feel comfortable making a referral to mental health

services. By the same token, mental health staff also have an obligation to communicate their findings back to the referral source as appropriate. The same courtesy is needed when a mental health inmate needs to be physically examined by staff. At one institution, staff reported poor cooperation between the mental health department and medical department. The heads of medical and mental health departments meet regularly to discuss the needs of both departments to reduce conflicts from occurring, which impact the patient's health. A similar procedure may need to be implemented and enforced at other institutions.

D. HEALTH EDUCATION

Education should be an important part of the Ohio correctional healthcare system. Not only does the education directly benefit the inmate, assisting inmates to improve their own health, but education also results in decreased medical costs to the Ohio taxpayer while the inmate is incarcerated and to the community once the inmate is released. For example, inmates who are given appropriate nutritional education may be able to reduce their weight and decrease their need for blood pressure, diabetes, cholesterol, or other medications related to higher weights.⁶⁷

Similarly, Ohio corrections should make nurse education a priority to ensure that inmates are receiving quality care, as anything less is likely to result in costly litigation.

1. Inmate Education

Educating inmates to be more aware and self-reliant with their health care is a fundamental element of a correctional health care professional's role. As one treatment provider relayed, staff have the opportunity to effect change in the lives of the women during their incarceration because so much of the inmate's environment is under the staff's control. Staff have relayed a belief that they may be missing opportunities to provide prevention education to inmates. Some staff also relayed that health education should be a part of re-entry programming.

However, the DRC does not currently provide a comprehensive educational program. Currently, health education is primarily conducted during the inmates' orientation to the facility. Orientation occurs within the first weeks of an inmate's arrival at the facility. The health education component, provided by a member of medical staff, covers very basic institutional information, such as how to file a health services request form to schedule an appointment to see medical staff. At the same time as inmates are receiving this information, they are adjusting to the institutional population, learning the rules of living in a dorm, feeling homesick due to the distance from family, and receiving

information regarding all other aspects of correctional life. While it is important for this information to be shared during orientation so that inmates know how to access medical services, the education does not go further than this. The majority of any additional education beyond orientation is provided informally, or provided with inmates during chronic care appointments.

As one example where education is needed, staff have relayed that many female inmates lack appropriate feminine hygiene practices. Inadequate education on hygienic practices may cause medical situations that could be avoided, such as yeast infections due to failure to change sanitary pads or toxic shock from using homemade tampons. Even basic skills such as cleanliness of undergarments and proper wiping have been reported as lacking.

The Northeast Pre-Release Center and Franklin Pre-Release Center^k have much smaller populations and staff at these institutions reported more opportunities to provide education. NePRC staff relayed that they conduct “town hall” meetings focusing on health topics in addition to annual health fairs required per policy.⁶⁸ Staff at NePRC also reported a higher level of staff involvement in the sanitation conditions of the facility by inspecting living quarters and shower facilities in the housing units. They believe this proactive approach prevents potential outbreaks of infectious diseases and demonstrates to the inmates that the staff is concerned for their wellbeing. These practices should be incorporated in the Ohio Reformatory for Women and the Dayton Correctional Institution, which has transitioned to housing a female population.

Staff at the Ohio Reformatory for Women relayed that the institution faced systemic problems that prevented a greater educational involvement with their patient, including staff turnover and overcrowding. However, DRC staff have relayed that both issues have been addressed, including the provision of a medical operations manager who has focused on staff retention and a reduction in the inmate population. It is therefore hoped that the improvements will lead to increased involvement of medical staff in inmate education, similar to that offered at the Northeast Pre-Release Center.

As one suggestion for how to provide health education, the institution should consider implementing a “health mentor” position for trained inmates, or an inmate group focused on health. Studies are limited,⁶⁹ but anecdotal evidence suggests that having peer support can positively influence weight loss⁷⁰ and potentially other health measurements. Health mentors or inmate group leaders could be given pre-screened information on medical conditions or could perform independent research through the institutional library and then lead educational sessions with their dorm or group. They

^k The Franklin Pre-Release Center transitioned in 2011 to a male population.

could assist in developing posters or activities that would promote awareness within the institution. While the health mentors or group leaders could not provide medical counsel, they could aid the institutional staff in creating an environment of health education.

A second solution that has already been implemented at a correctional institution is the creation of a specialized dorm that focuses on health. A model unit was created at the Northeast Ohio Correctional Center (NEOCC), a privately operated medium security male facility in Youngstown, Ohio. Inmates track a number of health-related measurements, including weight and fitness measures, such as ability to perform a certain number of push-ups, sit-ups, etc. Each inmate charts his progress over time. Inmates also lead aerobics and other exercise classes, and staff invite guest speakers to give presentations on health-related issues. The unit prioritizes inmates who are on the chronic care caseload or who otherwise have a documented medical need for health improvement. The unit is a merit unit, which also incentivizes positive inmate behavior. Staff reported that the unit has been extremely beneficial for the inmates, to the point that staff were considering implementing a second unit at the time of the CIIC inspection. DRC staff have already implemented smaller scale initiatives to encourage this type of group focus on health: staff at the Franklin Pre-Release Center reportedly ran a "Biggest Loser" competition among the female inmates that was very successful. Given the number of women involved in various weight loss programs in the community and the potential reduction in medical costs to the state, a similar unit can and should be considered for implementation at one or all of the female facilities.

2. Nurse Education

Keeping nurses involved in continuing education is also a fundamental element of patient care. Nurses need to be updated on current procedures and policies, as well as up to date methods of care, in order to provide the highest level of patient care. Many of the interviewed staff expressed a desire to continue their education with classes on specialized subjects, i.e., pregnancy, diabetes, and infectious diseases.

Aware of the positive impact training can have on quality assurance measures, the DRC currently provides a number of training opportunities, including monthly teleconferences, online medical education through the Ohio State University, an online resource for clinical questions, DRC's own medical education courses, collaborative training with local and county health departments, and mentorship.

In addition, the DRC conducts annual testing through an online resource to ensure that its medical staff are using best practices in the field. The DRC currently utilizes

Lippencott's Nursing Solutions, which is an interactive program that assists DRC nurses to not only maintain their nursing skills, but it also is a resource for patient care. The DRC provided the following description of the program:

[The program] provides detailed descriptions of procedures in a program that allows users to identify the procedure they need quickly and easily. Nurses can scroll through an alphabetical list, browse by nursing category or subcategory, or perform a search to identify a particular procedure. Each entry provides complete instructions, including the equipment needed, preparation guidelines, implementation steps, special considerations, documentation, and references. Video clips are included to clarify complex procedures. Each procedure is linked with at least one quick list. Quick lists provide a quick, less-detailed version of a procedure when only an overview is needed. Nurse-managers can use the program as an integrated system for assessing and tracking staff competency. Each procedure is linked with at least one skills checklist and a procedure test that allows nurse-managers to assess staff performance.

However, although the DRC offers its employees various training opportunities, some of the healthcare staff relayed that they were not aware of these resources,⁷¹ which suggests a need for increased advertisement of available training. Further, those who were aware of the training opportunities reported that they have difficulty getting time away from the institution to attend them, often citing staffing shortages as the primary reason.

As discussed above, the need for nurse education is especially salient for agency nurses, who may not undergo the same rigorous testing that the DRC nurses are given to ensure that their skills are up to date, and who need additional education on the DRC's policies and procedures.

E. TRANSITION TO DAYTON CORRECTIONAL INSTITUTION

A challenge facing the DRC is the transition of Dayton Correctional Institution (DCI) from a male institution to a female institution. This transition began in October 2011 and was expected to be completed by December 31, 2011. CIIC conducted an inspection of DCI's medical services on November 1, 2011.⁷² On the date of inspection, there were 643 female inmates housed at DCI, including 298 women on the chronic care caseload. The staff reported that they were seeing women for nurse sick call within 24 hours and the doctor was seeing them within 48 hours. CIIC staff conducted an inmate focus group of inmates both on the chronic care caseload as well as general medicine patients and the results were positive. The inmates praised the medical staff for

scheduling nurse and doctor sick calls in a timely manner and being respectful to them, both by listening to their medical complaints and by speaking to them in a respectful manner. The only concern expressed by inmates and staff was that the pill call line tends to be slow. This is a result of the influx of inmates needing medications. This institution has never experienced such a high volume of patients at pill call, but the staff reported the procedure is improving daily. As institutional staff adjust to the increased healthcare needs of the female population, the number of medical staff will have to be evaluated on an ongoing basis so that adjustments can be made if needed.

A primary concern regarding DCI's transition to a female institution is the large population of mental health inmates that will be housed at DCI. Historically, DCI has had less than ten inmates on the mental health caseload in any given month.⁷³ The transition to a female population brings with it hundreds of women on the mental health caseload. Not only will the institution require additional mental health staff to serve the population, but additional training is also needed for the security staff in the housing units, who had not formerly had to interact with a significant proportion of mentally ill inmates among their population. As housing unit staff will be the first to notice inmate behaviors that may indicate a need for a mental health referral, it is critical that they receive training.

CONCLUSION

The primary challenge facing correctional departments in regard to women's healthcare is simply the gravity of their needs. Female inmates are much more likely than males to report experiencing both a medical and a mental health problem. They therefore require far greater staff resources than male inmates do. In a restricted budgetary environment – such as that currently faced by the DRC – it is especially difficult to keep up with the pace of the women's healthcare demands. This problem will only increase, as the incarcerated female population continues to expand.

To give credit where credit is due, the DRC has made tremendous progress over recent years to improve healthcare for all inmates, including female inmates. This is due in large part to the *Fussell* litigation, as well as changes in administration. The DRC has also been very proactive in reducing the high costs of medical services to taxpayers. However, the DRC continues to face numerous challenges in its provision of adequate medical care to the female population. Current challenges include the recruitment and retention of quality healthcare staff, ensuring competent care at the Ohio Reformatory for Women, collaboration between medical and mental health departments, the provision of health education to both inmates and staff, and the transition of Dayton Correctional Institution to a female population.

The DRC's collaboration with CIIC on this report is indicative of its forward-thinking approach to correctional healthcare. CIIC will continue to monitor for concerns related to the healthcare provided to female inmates in DRC's care and to assist the DRC by identifying areas of concern that need to be addressed. CIIC commends the dedicated healthcare staff in both the institutions and the Operation Support Center and looks forward to reporting on the future progress and improvement in the care delivered to Ohio's incarcerated female population.

ENDNOTES

¹ Prison Inmates at Midyear 2009-Statistical Tables NCJ, Bureau of Justice Statistics.

² Ibid.

³ Medical Monthly Institutional Statistical Summary, ODRC, Ohio Reformatory for Women, Franklin Pre-Release Center, and Northeast Pre-Release Center, January 2009 – December 2010.

⁴ Fiscal Year Intake and Population on July 1, 1971-2009, by Sex, with Percentage Change from Preceding Year, and Monthly Fact Sheets, July 2010-2011. Ohio Department of Rehabilitation and Correction.

⁵ Ibid.

⁶ Maruschak, Laura (2008). Medical Problems of Prisoners. Bureau of Justice Statistics, United States Department of Justice. Accessed at <http://bjs.ojp.usdoj.gov/content/pub/pdf/mpp.pdf>. See also Anderson, Tammy, Ph.D. (2002). Issues in the Availability of Health Care for Women Prisoners. in press in *Female Prisoners in the United States: Programming Needs, Availability, and Efficacy*. edited by Susan Sharp, New Jersey: Prentice Hall. Retrieved from <http://www.udel.edu/soc/tammya/pdfs/Issues%20in%20the%20Availability%20of%20Healthcare%20for%20Women%20in%20Prison.pdf>.

⁷ Bickle, Gayle, M.A. Female Prisoners in Ohio, Ohio Department of Rehabilitation and Correction, Bureau of Planning and Evaluation, *Ohio Corrections Research Compendium*, Oct2002, Vol. I, p. 4-12. See also Anderson, 2002.

⁸ Ibid.

⁹ 2010 Intake, Bureau of Research and Evaluation, Ohio Department of Rehabilitation and Correction, July, 2011. <http://www.drc.ohio.gov/web/Reports/intake/Intake%202010.pdf>

¹⁰ Mustard, Cameron. (1998). Sex differences in the Use of Healthcare Services, *New England Journal of Medicine*, 338, pp. 1678-1683.

¹¹ Medical Monthly Institutional Statistical Summary, ODRC, Ohio Reformatory for Women, Franklin Pre-Release Center, and Northeast Pre-Release Center, January 2006 – December 2010.

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¹³ Personal communication to CIIC, August 29, 2011.

¹⁴ National health expenditures for prescription drugs increased from \$2.7 billion in 1960 to \$259.1 billion in 2010. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Change: Selected Calendar Years 1960-2010 [Data file]. Accessed at <http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf>.

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¹⁷ DRC Bureau of Mental Health Services Monthly Report, June 2011.

¹⁸ Ibid.

¹⁹ Ibid.

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²¹ Ibid and Bickle, 2002.

²² DRC, Bureau of Mental Health Services Monthly Report, June 2011.

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²⁸ DRC Policy 68-MED-23, "Women's Health Management."

²⁹ Ibid.

³⁰ Ibid.

³¹ Ibid.

³² Personal communication to CIIC, December 27, 2011.

³³ DRC Monthly Fact Sheets, January 2010 – December 2011. Available at www.drc.ohio.gov.

³⁴ Personal communication to CIIC, December 27, 2011.

³⁵ DRC Policy 68-MED-23, "Women's Health Management."

³⁶ Ibid.

³⁷ Ibid.

³⁸ Ibid. and Ohio Revised Code Section 5104.55.

³⁹ DRC Policy 68-MED-23, "Women's Health Management."

⁴⁰ Ibid.

⁴¹ As reported by institutional nurses to Bureau of Medical Services, June 2011.

⁴² Per SEC-310 series of DRC policies.

⁴³ Ibid.

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⁵⁰ *Achieving Baby Care Success Program Handbook*, provided by the DRC, p. 7.

⁵¹ Ibid. at p. 5.

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⁵⁷ CIIC database.

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⁵⁹ Personal communication to CIIC, December 27, 2011.

⁶⁰ Personal communication to CIIC, May 16, 2011.

- ⁶¹ CIIC Inspection Report on the Ohio Reformatory for Women. (2011, June 15). p. 88. Accessible through the CIIC website: www.ciic.state.oh.us.
- ⁶² Inmate communication to CIIC, February 23, 2011.
- ⁶³ Inmate communication to CIIC, July 28, 2011.
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- ⁶⁵ Inmate communication to CIIC, April 12, 2011.
- ⁶⁶ Inmate communication to CIIC, March 14, 2011.
- ⁶⁷ See, e.g., McLaughlin, T. T., Schweitzer, P. P., Carter, S. S., Yen, C. G., Lamendola, C. C., Abbasi, F. F., & Reaven, G. G. (2008). Persistence of improvement in insulin sensitivity following a dietary weight loss programme. *Diabetes, Obesity & Metabolism*, 10(12), 1186-1194. doi:10.1111/j.1463-1326.2008.00877.x; Vidal, J. (2002). Updated review on the benefits of weight loss. *International Journal of Obesity & Related Metabolic Disorders*, 26, 25-28; Oster, G., Thompson, D., Edelsberg, J., Bird, A. P., & Colditz, G. A. (1999). Lifetime Health and Economic Benefits of Weight Loss Among Obese Persons. *American Journal Of Public Health*, 89(10), 1536-1542.
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- ⁷⁰ See, e.g., Farris, Meg. (2010, November 17). Support Group Helps Members Lose Weight. Eyewitness News. WWLTV.com. Accessed at <http://www.wwltv.com/news/health/Together-weekly-support-groups-fight-obesity-108834864.html>. See also the popularity of weight loss support group programs such as Weight Watchers, TOPS, and Overeaters Anonymous.
- ⁷¹ Personal communication to CIIC, January 19, 2012.
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- ⁷³ Ibid.